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## PIONEER SERIES

Edward C. Senay, M.D.

### Lessons from Four Decades of Clinical Practice

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The leaders of modern addiction treatment are disengaging. Long-tenured pioneers in the field have retired or will soon retire. For those about to pass the torch of leadership, it is a time to

reflect, teach, and mentor. For those into whose hands this torch will be passed, it is a time for preparation. To acknowledge this generational transition, the author is conducting interviews with some of the modern champions of addiction treatment in the United States. This effort will honor these individuals and acknowledge that their work has made a great difference in the lives of individuals, families, and communities throughout the United States. This series will also give a new generation of addiction professionals and aspiring leaders an opportunity to learn from those who created the field they now inherit.

Dr. Ed Senay was recruited in 1969 from the Department of Psychiatry at the University of Chicago to work with Dr.

Jerome Jaffe in the development of the Illinois Drug Abuse Program (IDAP). IDAP became a widely replicated multi-modality system of addiction treatment in the 1970s. Over the ensuing four decades, Dr. Senay worked in a variety of clinical, research, and administrative roles and mentored many of the field's aspiring leaders, including this author. His work is widely acknowledged in the field. Dr. Senay has served on the editorial boards of many of the field's leading scientific journals, and he has consulted internationally on the clinical treatment of addictive disorders.

In the summer of 2010, I asked Dr. Senay to reflect on his work in the field and to share his thoughts about the future of addiction treatment. Join me in exploring the evolution of modern addiction treatment through Dr. Senay's experience.

### Medical/Psychiatric Training

**Bill White:** Dr Senay, there is much talk today about the need for improved medical education on the identification and

management of substance use disorders. What do you recall about such education during your medical and psychiatric training at Yale?

**Dr. Senay:** I was in medical school from 1952-1956. In this period, there was mention in the freshman psychiatry course of alcoholism, DTs and treatments for it, and AA as a referral source, but there was no mention of heroin or “drug abuse.” There were no treatment facilities for alcohol or substance abuse in most communities in those years, and there were strong institutional biases against addiction/alcoholism treatment. I remember talking with faculty people from some well known medical schools, and one of the doctors said, “Dr. Senay, don’t you know? We don’t want those people in our hospitals.” That’s pretty blunt, isn’t it?

**Bill White:** That’s very blunt. I remember when I first entered the field, there were still hospitals that had morality clauses in their bylaws that prohibited the admission of alcoholics and addicts.

**Dr. Senay:** I never heard of that, but I’m not surprised given the attitudes during that period. The attitudes of other medical specialties and emergency room nurses in particular—that was the primary point of contact with the world of drug abuse—were very, very negative. They just denigrated the people, and I can understand why in that climate people suffering from addiction would not come to us. Medicine had made advancements in understanding acute intoxication and its medical consequences in the late 1800s and the early 1900s, but by the time I got into medical school in the 1950s, we were going through a real downdraft. The Bureau of Narcotics had banned doctors from doing much with narcotic addiction so there was a void, and the big development as the years went by was the creation of NIDA—and then NIDA’s career teacher programs. That spawned the growth of the Association of Medical Education and Research in Substance Abuse (AMERSA). At this early point, there

were 78 specialists (yours truly was one) in separate medical schools who were devoted to improving teaching about substance abuse in the curriculum. That was an important beginning, but there was little scientific foundation for addiction medicine at that time, and meager funding limited its impact on medical education. In the seventies, we had three hours in the total four year curriculum devoted to alcoholism and drug addiction. To this date, there is not much more, although there is no recent study I know of with data on this question.

## Entering the Field

**Bill White:** Given the attitudes that you describe, what attracted you to the treatment of addiction as a clinical specialty?

**Dr. Senay:** Well, the first thing is that I liked the people. I wasn’t prepared to because of the prevailing attitudes I had encountered among older physicians whom I respected. I was surprised how much I liked working with the addicts. One case motivated me because he was getting up at five every morning and traveling in Chicago on buses to get to a job that barely paid for his bus fare. He had two buses each way each day, and he was studying at night. He wanted to get over his drug problems. He was from a minority family, and his ability to get to his job was almost lost because he had to cross street gang turf lines to get to one of the buses. Cases like his motivated me. Any help I could offer him helped me feel good about what I was doing. There were many patients in every clinic we built who were committed and successfully recovering. In addition, we had some treatments that for the first time we knew could help heroin addiction: methadone maintenance and Therapeutic Communities.

I also liked working with my professional peers. When Dr. Jerry Jaffe came to the University of Chicago, he brought beliefs very congruent with my own. He believed that addiction treatment should be public health oriented, should include multiple modalities and service options, and that people with drug dependence problems

should have real treatment choices. Those options included detoxification, therapeutic communities, methadone programs, outpatient counseling programs, etc. The model we built is still going today. In preparation for our discussion, I talked with some people at the Chicago Central Intake Facility. (Central Intake admitted to all the Chicago-based clinics of the Illinois Drug Abuse Program.) I asked them what numbers we're in now. As people enter intake into the publicly funded treatment in Chicago, they get a number. I was number 2 because in those days (1967), all staff got urine tested, so we also each got a number. That number today is over 250,000. And that's just in the publicly funded programs in the State of Illinois.

I was aware early on that we had something special, and it was particularly special for the black and Hispanic minorities who had had this problem for many decades but who had almost no treatment resources. Almost all the people we first admitted to IDAP in the late 60s had been to the federal narcotics hospitals in Lexington, Kentucky or Ft. Worth, Texas. There was only one 32-bed unit in Chicago (St. Leonard's House) when IDAP started that would accept addicts. Our early patients had tried these options, but nothing had helped them. Filling that vacuum was exciting. A group of us who were working in methadone programs—Bob DuPont from Washington DC, Bob Newman from New York, Barry Ramer from San Francisco, and a few others—really bonded and regularly met for a long time. We felt that we were breaking new ground and that we could help people in a way that had never before been available. This was all quite different from what I had planned my career to be, and I just fell in love with it.

**Bill White:** Did you have any sense even at that early point that this would be your life's work?

**Dr. Senay:** No, not at all. I went into it initially because Dr. Dan Freedman, Chairman of the Department of Psychiatry at the University of Chicago, said, "Help Dr. Jaffe out for a few months, and then you can go

back to your consultation liaison service." I was interested in psychiatric aspects of medical problems. So I did all the psychiatric consultations on all the wards of the hospital. I did them at Yale before I came to the University of Chicago, where I had planned to spend my career. But I got diverted to the treatment of drug problems and this new movement in medicine to create treatments for these disorders.

**Bill White:** I think our readers would be interested to know that this was occurring before there was a NIDA, NIAAA, or CSAT.

**Dr. Senay:** Yes. Those of us in these early programs recognized that we had a lot to tell each other about what was happening, and the federal government had begun exploring with us how to address these problems nationally. It was exciting because resources were being committed at an unprecedented level. After we opened the first clinics, we began to see that we really did have something to offer people suffering from addiction who had literally had nothing before. Our success in getting people to enter different kinds of research was extraordinary given the kinds of extremely negative feelings that most of the "addicts" had about universities and research, but we were able to get people involved. We published over 400 papers in the first 5 years of IDAP. NIDA was most supportive of the field, and a group of us wrote the first published manuals on drug treatment for NIDA-funded physicians. It was all a period of great learning and productivity, and it was fascinating and fun. I joined it happily.

## **The Illinois Drug Abuse Program**

**Bill White:** Could you provide more details on the components and scope of services provided at IDAP?

**Dr. Senay:** The first thing is that we had no beginning template. Let me give you a dramatic illustration of this. We admitted a 26-year-old female patient who was 6 months pregnant and was shooting \$500 of heroin a day. Her boyfriend was a high level

dealer, so she could get any amount of heroin she wanted. I could see from the intensity of her withdrawal that she probably had a very large habit. After I had finished my workup, I said, "Could you hang around for about 30 minutes? I want to talk to a colleague of mine about your problem." She agreed, and I went over to see Dr. Jaffe, explained the circumstances, and said, "What do I do?" He said, "I don't know. I don't know of any literature on this." He gave me a list of very prominent big city hospitals in the country to call, and I did. None of them knew what to do with a heroin addicted woman who was coming into the hospital to deliver a baby. That's where we were. We had to learn that you can't detox pregnant women without risk of losing the fetus, and we almost lost some of the women. There was just so much that we did not know at this early stage of modern treatment.

Consistent with his "different strokes for different folks" philosophy, Dr. Jaffe wanted to offer Therapeutic Communities as an option for those who were attracted to its drug free philosophy, so he recruited seasoned people who had been in Synanon, including David Deitch. Synanon was the prototypic Therapeutic Community. I learned a lot from David Deitch about TCs and the management of patients with heroin problems. Many street users of heroin did not want methadone, so we would explain Therapeutic Communities to them, and many opted for it. It was effective, very effective for some, and clearly needed to be included in recovery programs.

**Bill White:** I seem to recall that the polydrug counseling clinics also started fairly early in that period.

**Dr. Senay:** Yes. David Deitch started them. He got us to buy into the idea of drop-in centers for drug problems. You didn't have to tell your name. It wasn't medical; it wasn't psychiatric. It was a place where you could get food and some socializing together with a referral for treatment if you were ready for treatment. The unit was called Pflash Tyre. As more youthful polydrug users entered the treatment system, we were forced to alter

the adult model of treatment. We tried the adult TC model but found we quickly needed to abandon the harsh, confrontational style of that model. We changed it by listening. I was one of the staff who met with groups of these kids and told them simply, "Look, what we're doing we are not sure is helpful to you. What do you think you need, and how could your treatment be improved?" Through that process, we slowly evolved a TC model for adolescents at Crossroads and other sites in Chicago.

What's of interest to me is that the basic structure of what we put together is still there, but politics broke up our public health model in the middle 70s. Illinois' political leaders took the money that we were providing for treatment through IDAP and gave it to local communities so that they could pick whatever treatment they wanted. It had the virtue of providing jobs where jobs were desperately needed, but we lost much of the public health emphasis through that process. In these days of multiple severe drug problems co-occurring with HIV, Hepatitis C, major mental illness, poor education, etc., the loss of a public health modal impairs treatment enormously.

**Bill White:** Your reference to local communities and community politics raises the question of the community attitudes you encountered when you first began to set up TCs and clinics in Chicago neighborhoods.

**Dr. Senay:** The response was a strange one. It could be very warm or very rejecting, but many groups wanted to meet with us. At first, Dr. Jaffe would go, but then he would send me because he was often working with the Nixon White House or the state legislature. At first contact, everybody blessed us. But then more often than not, we would hear "Well, we know that you'd like to come into our community, but we don't have drug problems in our community. We don't want to draw people here who have these problems." This would come from neighborhoods in Chicago that were notorious drug using areas. I'll never forget one meeting where this very articulate, impressive young guy who was the head of

the community group summed up the evening's goings on with "Happily, we don't have heroin problems here. We support the treatment you are proposing, but not for here."

On the way out, he grabbed my arm and said, "Dr. Senay, could I talk to you?" He took me outside, and we got in his car. He said his brother, who lived in that community, was a heroin addict. Could I get him into treatment? You never knew what kind of jaw dropping stuff you might encounter when you went to these community meetings.

Dr. Jaffe and I did a lot of community work because there were so many communities in Chicago expressing at least a superficial interest in having a unit. We wanted to have as coherent and comprehensive a response as we could because legislators were always asking us, "What are you doing here? What are you doing there?" (IDAP was supported by funds from the State of Illinois as well as federal funds.)

**Bill White:** Did community resistance to treatment programs vary by modality?

**Dr. Senay:** We did not experience major resistance to TCs because they created no problems related to loitering, parking, or public intoxication, and they had less stigma attached to them than methadone clinics. Our real problem was with methadone. Methadone had a horrible reputation in minority communities at that time. There were a lot of addicts who would not take methadone. They just wanted the therapeutic communities. Our intention at first was to try to persuade people coming to us to accept random assignment to either methadone or to a TC, but we learned that there were many heroin dependent people strongly opposed to methadone who would not accept it under any circumstances. So our plan to do a comparative study on methadone versus Therapeutic Communities could not be implemented. I had clinical experiences that gave me arguments in support of methadone, and I heard from many family members of methadone patients that it was helping them

substantially or from others who wanted to get their son or daughter into our clinics because of the progress they saw in our patients in their community.

**Bill White:** This is a good opportunity for us to talk about the work you, Dr. Jaffe, and others achieved in the replication of methadone maintenance. How do you see the evolution of methadone maintenance and its current clinical and scientific status today?

**Dr. Senay:** From a scientific point of view, there's a reasonable chance that we're soon going to really understand the biotransformation of methadone in the body. That will enable us to further refine dosing practices in methadone treatment. Right now, there are many people whose basic biology for processing methadone never permits them to get a high enough dose to really be comfortable. If someone would say to me, "Well, what do you think should be next with federal priorities for money," I would say, "Unravel differences in the genetics of methadone biotransformation."

I once treated a young patient who was pregnant. We usually gave an initial dose of 40 milligrams of methadone per day in those days, but I only put her on 20 because I didn't think she was that dependent on opioids. She was in withdrawal, and there was no question that she was an addict. I raised her up to 30, and she stayed at 30, went through the pregnancy, never had any withdrawal, and then after the pregnancy, I withdrew her very slowly over about a six week period. She never had any trouble in withdrawal. She never had a positive urine for opioids. She was mentally clear and stated that she felt better on methadone than she could remember. Her biology is the template for what we're after. That's a potential I think is in the biology of every human, but we have not mined that potential yet. Understanding these differences in methadone metabolism will dictate the future of methadone treatment. Dr. Mary Jeanne Kreek has done important studies in this area, but there is

much left to be done, and this should be a high priority for NIDA.

**Bill White:** Dr. Senay, do you think a lot of the problems of continued drug use by methadone patients is related to the failure to achieve effective dose stabilization?

**Dr. Senay:** I think it's part of it, yes. Although the menu of drugs that people select who go into the drug culture is so varied now that it's really hard to say. There is a striking contrast between the first, say, 500 patients who came into IDAP and the last 500 who are coming through central intake in Chicago now. We initially saw people for whom heroin was clearly their primary drug, maybe a little bit of marijuana, maybe a little bit of occasional cocaine, and regular daily use of nicotine. That was it. Doesn't that sound strange in these days?

**Bill White:** Yes, the concept of primary drug had a lot of meaning in our early careers, and drug cultures were organized around primary drug choices, but that is much less the case today.

**Dr. Senay:** So you would agree with my feeling that that has changed dramatically?

**Bill White:** Yes, we have treatments that have been targeted to particular drug choices, but those treatments are confounded today by patterns of concurrent and sequential use of multiple drugs. The concept of "primary drug" has little meaning to many people entering addiction treatment today.

**Dr. Senay:** Exactly. In the initial 500 admissions in IDAP, we also did not see the range in severity of medical problems that there are now. There was no HIV. A few people had syphilis. One patient had tuberculosis. Four patients had subacute bacterial endocarditis. But that was it. None of them had Hepatitis A, or B, or C, which is now normative and brings profound health consequences. We have moved from post-adolescent onset of heroin use to pre-adolescent or early adolescent onset with all

of the telescoping of problem severity that this brings. With the multiple drug use and the medical and psychiatric complications, addiction treatment is a very different world today.

**Bill White:** Our talk of this increasing severity and complexity reminds me of a story that you once told me about a specialty clinic created within IDAP for patients who had failed in other programs. Could you describe that clinic and what was learned from its experience?

**Dr. Senay:** In IDAP, the basic menu for the addict was methadone or TCs and centralized ancillary medical and legal services—we employed two lawyers who helped our clients with their legal problems. Then Jerry and I put together a Special Treatment Unit. The Special Treatment Unit really started with failures in our line clinics. People would come with guns or intoxicated or whatever, and we would tell the patients, "You can't come to this clinic anymore. You've shown us that this clinic can't do it for you. But we will offer you a slot in our Special Treatment Unit, which is a regular methadone program with some special personnel." Our top clinician in the Special Treatment Unit (STU) was C. L., a onetime IDAP patient, who was one of our many ex-addict counselors. His street name was Superman. He was the best natural clinician I have ever seen. In the street world, his nickname was Superman because he was a very top line drug dealer. When we saw what a dramatic job he did with these failures in our line clinics, we started adding services to the STU. We didn't have enough money to have a psychiatrist in every clinic, but we could get one for the STU, and then we started thinking, "Why don't we have pregnancies come into the Special Treatment Unit too?" In the Special Treatment Unit, we delivered over 1,600 babies to women in treatment for addiction. What the Special Treatment Unit taught us was that with this kind of specialized programming, you can successfully treat people who would fail in mainstream treatment sites. So we wound up sending

our complicated cases with medical or psychiatric problems to the STU. This enhanced our services in the most economical way possible because the line clinics did not have to employ expensive specialists on their payrolls.

**Bill White:** One of the key ideas at IDAP was captured in the slogan “different strokes for different folks”—a motto that dominated IDAP long before anybody had heard of the phrase “treatment matching” or the notion that there are multiple pathways of recovery. Do you think we’re still struggling to learn that lesson you learned so early at IDAP?

**Dr. Senay:** As a field, yes. I think some people in the clinical world would know this instinctively after three weeks in an addiction clinic, but we still have a long way to go in terms of integrating this idea at the clinical practice level.

**Bill White:** What do you see as IDAP’s lasting legacies to the field?

**Dr. Senay:** One such legacy is the concept of central intake. In Chicago, addicts have had one place that they can go, and they can learn about treatment in 50 to 75 other places and pick which one they want, and the doctor at the central intake can send them to where he or she thinks they will experience the best person-program fit. That’s better programming than having 75 different intake procedures, and you avoid the financial or ideological conflicts of interest, e.g., modality or program bias of the assessor. I think we demonstrated that you could integrate multiple modalities within an overall administrative and clinical framework that could provide good treatment and address broader public health issues. We lost some of that public health orientation when these early systems were broken up. We now deal with HIV and tuberculosis and syphilis in one model, and we deal with addiction in another model, and I think the closer those models could get, the better off everybody would be.

## Modern Addiction Treatment

**Bill White:** What do you think are some of the most significant breakthroughs in the modern treatment of addiction?

**Dr. Senay:** I always resisted the idea that addicts could never get better, which tended to flow out of the idea of addiction as a chronic, relapsing disease. And it was true. You didn’t meet many people who’d been through the wringer and had come out alright for the rest of their lives. I think that has changed through modern treatment. We do see such people today. The possibility of cure in terms of permanent recovery is there now. I think the science is progressing and that new breakthroughs will create more effective treatments. I don’t think we are far away from the day when the successful patient I described earlier will be the norm rather than the exception in methadone treatment.

**Bill White:** I’m interested in your views on the current status of medications, some of the newer medications, and advancements addiction professionals might anticipate coming in the next decade.

**Dr. Senay:** Well, I don’t think it’s too much to suggest that we will be taking genetic profiles on everybody who comes through a central intake for addiction treatment. Those genetic profiles will tell us the kind of system each patient has for the biotransformation of the medication we’re giving them. Then I think there’s going to be a system of repair for those systems to make them adapt to what would be a good clinical course, like my ideal patient. I really think that once we know how to modify the biology of narcotics, our treatment’s going to be very different. And I think that’s what treatment will be about, and I think having these kinds of problems, you’re still going to need some counseling. So the basic prescription will remain: a doctor to take care of your medical problems, a counselor to take care of your psychological and social needs and the redevelopment of early ancillary services such as job training, job placement, legal

consultation, and others. It's hard to believe, isn't it, Bill, that we were doing those things? We were trying to help in every way we could think of.

**Bill White:** It is interesting that so many of us are now trying to push these non-clinical recovery support services like housing, education, and vocational and legal support services and that many of these existed in IDAP in the 1960s. In a related area, one of your early interests was the co-occurrence of addiction and various psychiatric disorders, particularly depression. What do you think are some of the more important lessons we've learned about treatment of addiction and co-occurring disorders?

**Dr. Senay:** The big lesson, I think—and every medical student should know this—is that you must treat both fully, or you're not going to get anyplace with either disorder. The money people are going to have to learn this. The way to reduce the overall drain on money in the long run is to treat them both vigorously. They're all balled up together. Someone who's overweight, for example, who also has any of these problems gets some little bit of variance toward being worse from the fact that there's co-occurring obesity. I'm very impressed by the research I'm reading lately that people who smoke marijuana also tend to smoke a little bit more nicotine and take a little bit more of whatever drugs they're monkeying around with. It's like each drug that's added to the cocktail increases the number of cocktails that they're going to take. So if you've got a person taking 10 drugs in a cocktail, they're going to be pretty severely addicted rapidly. Treatment of the future will be crafted on the results of studies of a series of mechanisms for fixing deficits in the biotransformations of different drugs.

**Bill White:** Are you surprised that there hasn't been a medication to replace methadone in all these years?

**Dr. Senay:** Yes, very.

**Bill White:** I know you were involved in some of the early research on LAAM, which seemed so promising early on.

**Dr. Senay:** Well, LAAM worked, and one thing that we never had a chance to research because it never got that big—and I don't think I could have gotten money for it—was there were some addicts who would tell you, "I like that LAAM stuff," and others would say, "No. Between methadone and LAAM, I like my methadone. Methadone stabilizes me." The ones who liked LAAM always spoke in terms of lightness. "It's not so heavy." It sounds as if they were a little bit more stimulated, a bit more awake, a little bit more aware from the LAAM. And I was thinking, "We've got to get the biology of that under control, and then we might really improve our overall treatment success."

**Bill White:** Let me take you to another area. In IDAP, you worked with primarily an ex-addict counseling staff, and you have witnessed the professionalization of that role over the past four decades. What do you feel has been gained or potentially lost through this process of professionalization of that role?

**Dr. Senay:** There were a lot of good reasons to have ex-addicts working at IDAP. They gave the clinics a kind of authenticity, and they could say far more effectively than non-addict staff, "Look, this is a clinic; it's not an extension of the street. We don't want street culture here. If you keep it up, you're going to have to move." A lot of people saw me as taking up for the ex-addict counselor, and I certainly used them when I thought that was appropriate, but I don't see any reason why people who have recovered from heroin addiction can't learn counseling. I do think that there is something from learning how to counsel people. My training at Yale I thought was great because the first thing that they taught us: you've got to listen to people. You've got to listen to your patients. We would make tapes, and they would say, "Now what are you hearing? What is the patient saying?" The whole thing was based on listening and then responding and



creating a bond, creating a therapeutic relationship. I still really believe in that.

**Bill White:** I was thinking of Superman and others who were your best clinicians. What do you think made them so effective?

**Dr. Senay:** This ability to listen. There are some people who, for whatever reason, have adopted listening styles in their interpersonal relationships. Maybe it's because their parents did that with them. Maybe they want to check out what it is like to be a different person and not from any desire to take them for anything. Con men do that, but only to know how best to manipulate. The bottom line is that people respond positively to effective listening. So I think the essence of addiction treatment is the structure of medical control to manage the biology of addiction and a relationship with the counselor who is interested in listening to you and building a relationship focused on changing your behavior and quality of life.

**Bill White:** I'm wondering if there are issues in the field that are of particular interest to you right now other than those that we've already touched on.

**Dr. Senay:** Well, I've continued to be quite interested in working with other countries. For about 12 years, I traveled to other countries once or twice a year under the sponsorship of the World Health Organization or the UN Narcotic Control Commission.

I have learned a lot from those trips. I recall an early trip to Indonesia in which I was asked to visit an institution that treated both people with addictions and people with various psychiatric illnesses. I was astounded how, once you took out the linguistic differences, the clinical appearance of schizophrenia on the island of Bali—that gorgeous place—is exactly like the clinical presentation of a case of schizophrenia in the United States. I have found these similarities and differences across cultures quite interesting.

**Bill White:** There is growing interest in applying principles of chronic disease management to the treatment of addiction. Do you think this holds promise for the future of treatment?

**Dr. Senay:** Yes. I think when the money guys get around to it, they will eventually see that this approach saves money in the long run and can make an enormous difference in the quality of peoples' lives.

## Retrospective

**Bill White:** When you look over your career, who are some of the people who have most influenced your views about addiction and recovery?

**Dr. Senay:** Dr. Jerry Jaffe is prominent on this list. I really liked his method of thinking about the heroin problem within a public health perspective and how to best create local and national systems of addiction treatment. Others of great influence on me included Dr. Dan Freedman, Dr. Vincent Dole, Dr. Herb Kleber, Dr. Bob DuPont, Dr. Sid Schnoll, and Dr. Bob Newman. These are just some of the people I really enjoyed working with over my career. I met with Dr. Dole a couple of times and came away feeling that I had been with the most intelligent person I've ever met as well as one of the nicest.

**Bill White:** When you review your career to date, what do you feel best about as you look back over those years?

**Dr. Senay:** More than anything, it has been the people—the patients and the professionals I worked with. When people ask me, "Are you happy with the career you picked?" I say, "Absolutely." I can't imagine doing anything other than this, and I've had a good time doing it.

**Bill White:** I'm really struck by the optimism you have about the future of treatment.

**Dr. Senay:** Treatment is going to get more and more effective, and that will lead us to

greater attention on some of the social forces that contribute to addiction, such as the marketing forces and the information/entertainment industries that continue to portray drug use in such glamorous ways in spite of the continued drug casualties within that industry and the fact that a significant fraction of our young people are burdened with a drug problem that really changes their lives in a very major and very negative way,

**Bill White:** Are there any final words you would offer a person considering entering professional work in the addiction treatment field?

**Dr. Senay:** It's fascinating, and if you like people, the kinds of problems drug dependent people have are reachable often enough to make your efforts rewarding. It may not be for everybody, but it worked very well for me. One thing that may explain that is my having grown up in foster homes.

If you grow up in foster homes, you have some understanding of what the world looks like to people "on the outside looking in." If you can establish an effective clinical relationship with a patient with one of these problems, it puts you both inside for a time, and that feels very good for both patient and doctor.

**Bill White:** People often ask me if I feel that helpers have to be in recovery to work effectively in addiction treatment. I don't believe that is the case, but I do feel such helpers need to find a source of empathic identification with the emotional pain and social alienation that is such a core of the addiction experience.

**Dr. Senay:** I would agree with you.

**Bill White:** Dr. Senay, thank you for all you have done for our field, and a personal thank you on behalf of all of those you have mentored over these past decades.